UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

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ALICE LAZARUS HABER,

Plaintiff,

-against-

NATIONAL RAILROAD PASSENGER CORPORATION d/b/a AMTRAK, METROPOLITAN TRANPORTATION AUTHORITY, LONG ISLAND RAILROAD COMPANY and ABM INDUSTRIES, INC.,

Defendants.

----------X

07 CV 7060

PLAINTIFF'S RESPONSE TO DEFENDANTS REQUEST FOR PRODUCTION OF DOCUMENTS

Plaintiff, ALICE LAZARUS HABER, by and through her attorneys, LEAV & STEINBERG, LLP, hereby responds to the Defendants First Request for Production of Documents as follows:

1) Plaintiff is not in possession of any adverse party statements.

2) Annexed hereto as Exhibit "A" are copies of plaintiff's medical records from the following providers:

a) Saint Vincent Catholic Medical Centers
153 West 11th Street
New York, NY 10011

b) Manor Care Potomac
10714 Potomac Tennis Lane
Potomac, MD 20854

c) Adventist Home Health:
12041 Bournefield Way, Suite B
Silver Spring, MD 20904

d) Bethesda-Chevy Chase Orthopaedic
Dr. Cannova
10215 Fernwood Road
Bethesda, MD 20817

e) Zupnik, Winson and Chen, D.D.S., P.A.
8218 Wisconsin Avenue, Suite 203
Bethesda, MD 20814

f) Dr. Gerald S. Gordon
8001 Inspection House Road
Potomac, MD 20854

g) Cohen, Goodman, Simon, Ribera and Menhinick, P.A.
5454 Wisconsin Avenue, Suite 1355
Chevy Chase, MD 20815-6921

3) Annexed hereto as Exhibit "B" are duly executed HIPPA compliant authorizations for the release of plaintiff's medical records from the following providers:

a) Saint Vincent Catholic Medical Centers
153 West 11th Street
New York, NY 10011

b) Manor Care Potomac
10714 Potomac Tennis Lane
Potomac, MD 20854

c) Adventist Home Health:
12041 Bournefield Way, Suite B
Silver Spring, MD 20904

d) Bethesda-Chevy Chase Orthopaedic
Dr. Cannova
10215 Fernwood Road
Bethesda, MD 20817

e) Zupnik, Winson and Chen, D.D.S., P.A.
8218 Wisconsin Avenue, Suite 203
Bethesda, MD 20814

f) Dr. Gerald S. Gordon
8001 Inspection House Road
Potomac, MD 20854

g) Cohen, Goodman, Simon, Ribera and Menhinick, P.A.
5454 Wisconsin Avenue, Suite 1355
Chevy Chase, MD 20815-6921

4) Plaintiff was not employed at the time of the accident and remains unemployed, therefore this demand is not applicable.

5) Please refer to response 4 above.

6) Please refer to response 4 above.

7) Annexed hereto as Exhibit "C" are copies of photographs, in plaintiff's possession, depicting the location of the accident.

Plaintiff reserves the right to supplement and/or amend the information provided above until the time of trial.

Dated: New York, New York
October 30, 2007

Yours, etc.,
LEAV & STEINBERG, LLP

By: _____
DANIEL T. LEAV (DTL 5145)
Attorneys for Plaintiff
120 Broadway, 18th Floor
New York, New York 10271
(212) 766-5222

TO:

LANDMAN CORSI BALLAINE & FORD P.C.
By: Ronald E. Joseph
Attorneys for Defendants
NATIONAL RAILROAD PASSENGER CORPORATION d/b/a AMTRAK, METROPOLITAN TRANSPORTATION AUTHORITY and LONG ISLAND RAILROAD COMPANY
120 Broadway, 27th Floor
New York, New York 10271
(212) 238-4800

CERTIFICATE OF SERVICE

I certify that under penalty of perjury pursuant to 28 U.S.C. Section 1746 that on November 1, 2007, I caused to be served upon the following, by First Class United States Mail, postage prepaid, a true copy of the attached Plaintiffs' Automatic Disclosure by depositing same in a postage-paid envelope in a U.S. Postal Box within New York addressed to:

COUNSEL FOR DEFENDANT

LANDMAN CORSI BALLAINE & FORD P.C.
By: Ronald E. Joseph
120 Broadway, 27th Floor
New York, New York 10271

Dated: New York, New York
November 1, 2007

DANIEL T. LEAV (DTL 5145)

EXHIBIT "B"

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Alice Lazarus Haber	11-30-33	219-32-9195

Patient Address: 5800 Nicholas Lane, Rockville, MD 20852

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
GOODMAN, P.A. 5454 Wisconsin Ave, Suite 1355, Chevy Chase, MD 20815

8. Name and address of person(s) or category of person to whom this information will be sent:
Landman, Corsi, Ballain & Ford

9(a). Specific information to be released:

☐ Medical Record from (insert date) _____ to (insert date) _____

☒ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider)

to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:
☒ At request of individual
☐ Other:

11. Date or event on which this authorization will expire:
At end of litigation

12. If not the patient, name of person signing form:

13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Alice Lazarus Haber
Signature of patient or representative authorized by law.

Date: 11/1/07

* Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Alice LAZARUS HABER	11-30-33	219-32-9195
Patient Address		
5800 Nicholas Lane, Rockville, MD 20852		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT,** except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Dr. GERALD S. Gordon, 8001 Inspection House Rd, Potomac, MD 20854

8. Name and address of person(s) or category of person to whom this information will be sent:
LANDMAN, Corsi, BALLAINE & Ford

9(a). Specific information to be released:

☐ Medical Record from (insert date) _____ to (insert date) _____

☒ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

_____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider)

to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:
☒ At request of individual
☐ Other:

11. Date or event on which this authorization will expire:
At End of litigation

12. If not the patient, name of person signing form:

13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Alice Lazarus Haber

Signature of patient or representative authorized by law.

Date: 11-1-07

* Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Alice Lazarus Haber	11-30-33	219-32-9195
Patient Address: 5800 Nicholas Lane, Rockville, MD 20852		

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2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Zupnik, Winson And Chen, DDS; 8218 Wisconsin Ave, Bethesda, MD 20814

8. Name and address of person(s) or category of person to whom this information will be sent:
Landman, Cors; Ballaine & Ford; 120 Broadway, 27th Fl. NY, NY 10271

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☒ At request of individual ☐ Other:	At End of Litigation
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Alice Lazarus Haber

Signature of patient or representative authorized by law.

Date: 11/1/07

* Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

OCA Official Form No.: 960

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[This form has been approved by the New York State Department of Health]

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Patient Address: 5800 Nicholas Lane, Rockville, MD 20852		

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6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Bethesda-Chevy Chase Ortho, 10215 Fernwood Rd; Bethesda MD 20817

8. Name and address of person(s) or category of person to whom this information will be sent:
Landman, Corsi, Ballaine & Ford; 120 BDWAY, 27th Fl. NY, NY 10271

9(a). Specific information to be released:

☐ Medical Record from (insert date) _____ to (insert date) _____

☒ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

_____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:
☒ At request of individual
☐ Other:

11. Date or event on which this authorization will expire:
At end of litigation

12. If not the patient, name of person signing form:

13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Alice Lazarus Haber
Signature of patient or representative authorized by law.

Date: 11/1/07

* Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

OCA Official Form No.: 960

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Patient Address: 5800 Nicholas Lane, Rockville, MD 20852		

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2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Adventist Home Health; 12041 Bournefield Way, Suite B, Silver Spring, MD 20904

8. Name and address of person(s) or category of person to whom this information will be sent:
Lanpman, Corsi, Ballaine & Ford; 120 Broadway, 27th Fl. NY, NY 10271

9(a). Specific information to be released:

☐ Medical Record from (insert date) _____ to (insert date) _____

☒ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☒ At request of individual ☐ Other:	18 months from signing
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Alice Lazarus Haber

Signature of patient or representative authorized by law.

Date: 11/1/07

* Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Alice LAZARUS HABER	11-30-33	219-32-9195
Patient Address		
5800 Nicholas LANE, Rockville, MD 20852		

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2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
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6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Manor Care Potomac; 10714 Potomac Tennis Lane, Potomac, MD 20854

8. Name and address of person(s) or category of person to whom this information will be sent:
Landman, Corsi, Ballaine & Ford, 120 Broadway, 27th Fl. NY, NY 10271

9(a). Specific information to be released:

☐ Medical Record from (insert date) _____ to (insert date) _____

☒ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

_____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider)

to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☒ At request of individual ☐ Other:	At End of litigation
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Alice Lazarus Haber

Signature of patient or representative authorized by law.

Date: 11/1/07

* Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Alice Lazarus Haber	11-30-33	219-32-9195
Patient Address: 5800 Nicholas Lane, Rockville, MD 20852		

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1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
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4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Saint Vincent's, 153 West 11th St., NY, NY 10011

8. Name and address of person(s) or category of person to whom this information will be sent:
Landman, Corsi, Ballaine & Ford, 120 Broadway, 27th Fl. NY, NY 10271

9(a). Specific information to be released:

☐ Medical Record from (insert date) _____ to (insert date) _____

☒ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers. ME #1324702

☐ Other: _____

_____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:
☒ At request of individual
☐ Other:

11. Date or event on which this authorization will expire:
At End of Litigation

12. If not the patient, name of person signing form:

13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Alice Lazarus Haber

Signature of patient or representative authorized by law.

Date: 11-1-07

* Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

07 CV 7060

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ALICE LAZARUS HABER,

Plaintiff,

- against -

NATIONAL RAILROAD PASSENGER CORPORATION d/b/a AMTRAK, METROPOLITAN TRANSPORTATION AUTHORITY, LONG ISLAND RAILROAD COMPANY and ABM INDUSTRIES INC.,

Defendant.

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PLAINTIFF'S RESPONSE TO DEFENDANT'S FIRST REQUEST FOR PRODUCTION OF DOCUMENTS

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New York, NY 10271
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